

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-031143

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 375 Primary Registration District No. 6288 Registrar's No. 16

FILED JUL 22 1963

VS 300
Rev. 4/59

DATE AMENDED

1 1140

2 1140

3

4 0

5 0

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7 0

8 0

9 240

10 18

11 114

12 90-3

13 1-0

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>Wright</u>		STATE <u>Missouri</u> b. COUNTY <u>Wright</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Union Twp.</u> Length of stay in lb <u>2 mo.</u>		c. CITY OR TOWN <u>Grovespring</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Grovespring</u>		d. STREET ADDRESS (If outside, give location) <u>Rural Route</u> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kevin Darrell Jones</u>		4. DATE OF DEATH Month Day Year <u>July 11 1963</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5/7/1963</u>
9. AGE (last birthday) <u>2</u> IF UNDER 1 YEAR Months Days		10. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lebanon mo.</u>	
11. BIRTHPLACE (City and state or country) <u>Lebanon mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James D. Jones</u>		13b. MOTHER'S MAIDEN NAME <u>Patricia M. Ginty</u>	
14. NAME OF HUSBAND OR WIFE <u>none</u>		15. SOCIAL SECURITY NO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT Address <u>James D. Jones Grovespring mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
IMMEDIATE CAUSE (a) <u>Asphyxiation</u>			
DUE TO (b) <u>Beamed w/opp in clothing during night and accidentally suffocated</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>1:00 a.m.</u> to <u>1:00 a.m.</u> and last saw her/him alive on <u>7-11-63</u> . Death occurred at <u>1:00 a.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Thomas M. Crowe Wright Co.</u>		22b. ADDRESS <u>W. H. Crowe Mo.</u>	
		22c. DATE SIGNED <u>7-5-63</u>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial</u>		23b. DATE <u>7/12/1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cuba Cemetery near Grovespring, mo.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR <u>Dorsey M. Howe Lebanon mo.</u>		25. DATE RECD. BY LOCAL REG. <u>7-19-1963</u>	
		26. REGISTRAR'S SIGNATURE <u>Bonnie J. Jones</u>	

USE BLACK INK OR TYPEWRITER RIBBON

STATE OF MISSISSIPPI

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Dorsey M. Howe

Licensed Embalmer No. 4222

P. O. Address Lebanon, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.